EVALUATION OF THE CERTIFICATE OF NEED APPLICATION SUBMITTED ON BEHALF OF GOOD SAMARITAN HOSPITAL PROPOSING TO ADD THIRTY ACUTE CARE BEDS TO THE EXISTING HOSPITAL

PROJECT DESCRIPTION

Good Samaritan Hospital (GSH) is a Washington State non-profit hospital located at 407 14th Avenue Southeast in the city of Puyallup, within Pierce County. GSH is currently a provider of Medicare and Medicaid acute care services to the residents of central and east Pierce County and surrounding areas. The hospital is licensed for 225 acute care beds, holds a three-year accreditation from the Joint Commission on Accreditation of Healthcare Organizations, and is designated as a level III trauma hospital and a level I adult trauma rehabilitation hospital. Additionally, GSH is one of four level I pediatric trauma rehabilitation hospitals in Washington State. The hospital also is approved to operate an intermediate care nursery and level II obstetric services. [source: CN historical files, DOH Office of Health Care Survey, and Office of Emergency Medical and Trauma Prevention]

This application proposes to add 30 acute care beds to its existing 225 acute care beds, for a facility total of 255 acute care beds. The 30 beds would be added in as the second of two phases in a larger facility expansion, which is described below.

Phase One

Construction of a new emergency department and patient care tower will begin in May 2008. By April 2010, the emergency department and one floor of inpatient rooms will be completed. These rooms will replace existing capacity and will not increase licensed beds. This phase requires no construction or purchase of equipment that is applicable to the project and, therefore, requires no capital expenditure. [source: Application, p16]

Phase Two

With the completion of the new patient tower, a new 30-bed medical/surgical unit will be completed on Level 6. These beds represent the project discussed in this evaluation. Phase two would be complete and operational by September 2011. The original estimated capital expenditure associated with the acute care addition in this phase is $8,134,878. [source: Application p16] The revised capital expenditure, according to later documents, is $12,228,385. [source: May 22, 2006, PUI comments]

As stated above, the estimated capital expenditure for the project is $12,228,385, and is solely attributed to phase two. Of the total capital expenditure, 67% is related to construction; 18% is related to equipment; 1% is related to Washington State sales tax; and the remaining 14% is related to fees.

APPLICABILITY OF CERTIFICATE OF NEED LAW

This project is subject to Certificate of Need review as the change in bed capacity of an existing health care facility under the provisions of Revised Code of Washington (RCW) 70.38.105(4)(e) and Washington Administrative Code (WAC) 246-310-020(1)(c).

APPLICATION CHRONOLOGY

March 3, 2004	Letter of Intent Submitted
September 7, 2004	Application Submitted
September 7 2004 through November 30, 2005	Department's Pre-Review Activities • 1st screening activities and responses • 2nd screening activities and responses
January 7, 2005	Department Begins Review of the Application • Public comments accepted throughout review
February 28, 2005	Public Hearing Conducted/End of Public Comment
June 28, 2005	Review Suspended at Request of Applicant
May 15, 2006	Review Resumes/Department Declares Pivotal Unresolved Issue (PUI)
May 22, 2006	PUI Information Submitted
July 21, 2006	Department's Anticipated Decision Date
July 27, 2006	Department's Actual Decision Date

AFFECTED PARTIES

The following entity sought and received affected person status under WAC 246-310-010:

- MultiCare Health System, owner and operator of Tacoma General/Allenmore Hospital and Mary Bridge Children's Hospital, located in the city of Tacoma within Pierce County.

SOURCE INFORMATION REVIEWED

- Good Samaritan Hospital's Certificate of Need Application received September 7, 2004
- Good Samaritan Hospital's supplemental information dated November 29, 2004
- Community members' comments
- Documents and comments received at the February 28, 2005, public hearing
- Comprehensive Hospital Abstract Reporting System (CHARS) data obtained from the Department of Health's Office of Hospital and Patient Data Systems
- Financial feasibility and cost containment evaluation prepared by the Department of Health's Office of Hospital and Patient Data Systems (July 27, 2006)
- Historical charity care data obtained from the Department of Health's Office of Hospital and Patient Data Systems (2002, 2003, and 2004 summaries)
- Population data obtained from the Office Financial Management based on year 2000 census published January 2002.
- Licensing and/or survey data provided by the Department of Health's Office of Health Care Survey
- Emergency and trauma designation data provided by the Department of Health's Office of Emergency Medical and Trauma Prevention
- Acute Care Bed Methodology extracted from the 1987 State Health Plan
- Data obtained from Good Samaritan Hospital's website
- Information obtained from the internet regarding Good Samaritan Hospital's project
- Certificate of Need Historical files

CRITERIA EVALUATION

To obtain Certificate of Need approval, Good Samaritan Hospital must demonstrate compliance with the criteria found in WAC 246-310-210 (need); 246-310-220 (financial feasibility); 246-310-230 (structure and process of care); and 246-310-240 (cost containment), and portions of the 1987 State Health Plan as it relates to the acute care bed methodology.[1]

CONCLUSION

For the reasons stated in this evaluation, the Certificate of Need application submitted on behalf of Good Samaritan Hospital to add 30 acute care beds to the hospital is not consistent with the Certificate of Need review criteria, and a Certificate of Need should be denied.

[1] Each criterion contains certain sub-criterion. The following sub-criteria are not discussed in this evaluation because they are not relevant to this project: WAC 246-310-210(3), (4), (5), and (6).

A. Need (WAC 246-310-210)

Based on the source information reviewed, the department determines that the applicant has met the need criteria in WAC 246-310-210.

(1) The population served or to be served has need for the project and other services and facilities of the type proposed are not or will not be sufficiently available or accessible to meet that need.

The department uses the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan to assist in its determination of need for acute care capacity. This forecasting method is designed to evaluate need for additional capacity in general, rather than identify need for a specific project. The department prepared bed need forecasts relying on data provided by the applicant to determine baseline need for acute care capacity. This set of projections is completed prior to determining whether the applicant should be approved to meet any projected need. Because data from the applicant was relied on in generating the department's forecasts, GSH's project is discussed in the evaluation of need below.

As stated in the project description portion of this evaluation, GSH proposes to add 30 acute care beds to its existing 225 acute care beds. The 30 beds would be added in the second of two phases. Given that this phase involves construction, GSG anticipates it to be complete and operational by September 2011; with a facility total of 255 beds. [source: May 22, 2006 PUI responses]

GSH provided three different versions of the numeric methodology: the first, submitted in response to the department's screening questions, was prepared using 1996-2002 historical data; the second, submitted by GSH's consultant at the public hearing in February, 2005, was prepared using 1996-2003 data; and the third, submitted with GSH's PUI responses, was prepared using 1996-2004 historical data. The first and third versions are summarized here and explained in greater detail within the step-by-step portion of the numeric methodology explanation within this evaluation – the first because it is the methodology upon which the initial evaluation was founded; the third because it is the final iteration of the methodology presented by the applicant, in response to the department's PUI request. Further, GSH used a seven-year horizon for forecasting its projections, which is consistent with the recommendations within the state health plan which states, "For most purposes, bed projections should not be made for more than seven years into the future." Further, a seven year forecast is consistent with most projects for hospital bed additions reviewed by the CN Program. As a result, the department will focus on the target year 2013; however, in some areas of this evaluation, the year 2010 may be referenced for demonstrative purposes.

In the first version, submitted in November, 2004, as a response to the department's screening questions, GSH based its projections on hospital discharges for years 1996 - 2002. This version resulted in a projected total of 54,866 patient days in year 2005; which increases for years 2007 and 2008 to 57,935 patient days and 59,521 patient days, respectively. Year 2012 projections show 65,630 patient days. Using this version, GSH determined a surplus of beds in the planning area through year 2006, with a need for 2 beds in year 2007, and 8 beds in year 2008. By the end of year 2012, this version calculated a need for 32 beds in the

planning area. At the time this methodology was submitted, the anticipated seven-year projection year was 2012.

In the third version, GSH based its projections on the hospital discharge data for years 1996 - 2004. This version resulted in a projected total of 52,085 patient days in 2006; which increases to 53,838 and 55,668 patient days for years 2007 and 2008, respectively. Year 2013 projections show 63,683 patient days. Using this version, GSH projected a surplus of 21 beds in year 2006. This bed surplus decreases to 14 beds in 2007; 7 beds in 2008, and results in a need for 24 beds in 2013. GSH carried this version of the methodology through 2015, projecting 67,101 patient days and a need for 38 additional beds. [source: May 22, 2006, PUI information]

The Department's Determination of Numeric Need:

The determination of numeric need for acute care hospital beds is performed using the Hospital Bed Need Forecasting Method contained in the 1987 Washington State Health Plan (SHP). Though the SHP was "sunset" in 1989, the department has concluded that this methodology remains a reliable tool for predicting the baseline need for acute care beds.

The 1987 methodology was a revision of an earlier projection methodology prepared in 1979 and used in the development of subsequent State Health Plans. This methodology was developed as a planning tool for the State Health Coordinating Council (SHCC) to facilitate long-term strategic planning of health care resources. The methodology is a flexible tool, capable of delivering meaningful results for a variety of applications, dependent upon variables such as referral patterns, age-specific needs for services, and the preferences of the users of hospital services, among others.

The 1987 methodology is a twelve-step process of information gathering and mathematical computation. The first four steps develop trend information on hospital utilization. The next six steps calculate baseline non-psychiatric bed need forecasts. The final two steps are intended to determine the total baseline hospital bed need forecasts, including need for short-stay psychiatric services: step 11 projects short-stay psychiatric bed need, and step 12 is the adjustment phase, in which any necessary changes are made to the calculations in the prior steps to reflect conditions which might cause the pure application of the methodology to under- or over-state the need for acute care beds.

The completed methodology is presented as a series of appendices to this evaluation. The methodology presented here incorporates all adjustments that were made following preparation of the methodology. Where necessary, both adjusted and un-adjusted computations are provided. The methodology uses population and healthcare use statistics on several levels: statewide, Health Service Area (HSA) [2], and planning area. The planning area for this evaluation is the East Pierce planning area located in HSA 1. State Health

[2] The state is divided into four HSAs by geographic groupings. HSA 1 is composed of Clallam, Island, Jefferson, King, Kitsap, Pierce, San Juan, Skagit, Snohomish, and Whatcom Counties. HSA 2 is composed of Clark, Cowlitz, Grays Harbor, Klickitat, Lewis, Mason, Pacific, Skamania, Thurston, and Wahkiakum counties. HSA 3 is composed of Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Okanogan, and Yakima Counties. HSA 4 is composed of Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman counties.

Planning and Development Agency documents from 1981 describe the three planning areas in Pierce County as follows:

"The Central Pierce planning area contains the City of Tacoma and surrounding communities of Fircrest, South Tacoma, and Fife, as well as the lower Kitsap peninsula which lies in Pierce County…

"West Pierce includes Steilacoom, Lakewood and Parkland, and the Fort Lewis and McChord Military installations…

The East Pierce planning area covers the remainder of Pierce County east to the Cascades, and includes the Milton, Puyallup, Sumner, and Orting…"

The planning area descriptions above were accompanied by a list of 23 contiguous Pierce County zip codes. Because some zip codes have changed, have been eliminated, or have been added since the creation of the planning area descriptions, GHS provided a list of 24 zip codes that it believes currently meet the description of the East Pierce planning area. In examining GSH's interpretation of East Pierce, the department notes that two of the original zip codes no longer exist and four additional zip codes have been created within the original East Pierce planning area. GSH recognized these changes in preparing its methodology, but also excluded two existing zip codes traditionally included in East Pierce and included one zip code traditionally included in the Southeast King planning area. GSH did not explain these changes. Without explanation, and upon comparison of the changes to historical evaluations and planning documents, the department concludes that the latter two changes are not appropriate.

When preparing acute care bed need projections, the department relies upon population forecasts published by the Washington State Office of Financial Management (OFM). OFM publishes a set of forecasts known as the "intermediate-series" county population projections, based on the 2000 census, developed January 2002[3]. These forecasts are not, however, available for any area smaller than an entire county. As a result, the department generally relies upon sub-county population projections provided by applicants, provided they are obtained from a reliable source. In this application, GSH has provided sub-county population projections developed by Claritas, a recognized source of demographic information. GSH's population projections, however, are based upon its planning area discussed above. Because the department's interpretation of the planning are and GSH's differ, the department used available historical population estimates for the three zip codes in question (98047, 98446, and 98447) to modify the population projections provided by GSH. This difference between GSH's projections and the departments is consistent throughout.

This portion of the evaluation will describe, in summary, the calculations made at each step and the assumptions and adjustments made in that process. It will also include a review of any deviations related to the assumptions or adjustments made by GSH in its application of the methodology.

The titles for each step are excerpted from the 1987 SHP.

[3] Found on the World Wide Web at http://www.ofm.wa.gov/pop902020/pop902020toc.htm and at http://www.ofm.wa.gov/pop/april1/finalpop2004.xls.

Step 1: Compile state historical utilization data (i.e., patient days within major service categories) for at least ten years proceeding the base year.

For this step, attached as Appendix 1, the department obtained utilization data for 1996 through 2004 from the Department of Health's Office of Hospital and Patient Data Systems' CHARS (Comprehensive Hospital Abstract Reporting System) database. Total patient days were identified for the East Pierce Planning Area, HSA #1, and Washington State as a whole, excluding psychiatric patient days [Major Diagnostic Category (MDC) 19] and normal newborns [Diagnostic Related Group (DRG) 391], according to the county in which care was provided. Normal newborn days (DRG 391) were excluded because the normal newborn patients (babies) do not occupy a licensed acute care bed. The mothers of the normal newborns are included in the patient days (MDC 14 and DRG 370-384). The limitation of this table to eight years' data, rather than ten years' data, is discussed in step 4, below.

GSH followed this step as described above with no deviations.

Step 2: Subtract psychiatric patient days from each year's historical data.

This step was partially accomplished by limiting the data obtained for Step 1, above. The remaining data still included non-MDC 19 patient days spent at psychiatric hospitals. Patient days at dedicated psychiatric hospitals were identified for each year and subtracted from each year's total patient days. The adjusted patient days are shown in Appendix 2.

GSH also followed this step as described above with no deviations.

Step 3: For each year, compute the statewide and HSA average use rates.

The average use rate (defined as the number of patient days per 1,000 population) was derived by dividing the total number of patient days in each HSA by that HSA's population and multiplied by 1,000. Using the same process, the average use rate was also determined for the East Pierce planning area and is attached as Appendix 3. Historical and projected population figures for this analysis were derived using the process discussed on page 6 of this evaluation.

Except for differences in population rates discussed on page 6 of this evaluation, GSH followed this step as described above with no deviations.

Step 4: Using the ten-year history of use rates, compute the use rate trend line, and its slope, for each HSA and for the state as a whole.

The department has previously determined that changes in the healthcare delivery system occurring in the first few years of the most recent ten years, such as changes in the federal Medicare reimbursement system and increasing application of managed care principles, were responsible for a sharp decline in use rates during the period 1993-1995. It is the department's conclusion that these factors represent an adjustment in the delivery of healthcare that is unlikely to be duplicated in the near future. As a result, the department has concluded that the period 1996-2004 more accurately represents use rates at present and for the foreseeable future. Consequently, the department computed trend lines for the state, HSA #1, and the East Pierce planning area based upon the trends in use rates from these eight years and included them as Appendix 4. The resulting trend lines uniformly exhibit a mild

upward slope. This conclusion is generally supported by increasing utilization reported by hospitals throughout the state in recent years, and may be indicative of a growing population. More significant than overall population growth is the fact that the state's population is growing older as the large number of "baby boomers" (those born from 1946 to 1964) age and begin to demand more health services. Utilization of hospital beds by patients aged 65 and older is significantly higher than bed utilization by younger patients, as demonstrated in subsequent calculations.

GSH also followed this step as described above; however, GSH's calculations returned a mild downward slope for the planning area, a result of the slightly different definitions used by GSH and department for the East King planning area. This deviation would impact future steps noted within this methodology.

Step 5: Using the latest statewide patient origin study, allocate non-psychiatric patient days reported in hospitals back to the hospital planning areas where the patients live. (The psychiatric patient day data are used separately in the short-stay psychiatric hospital bed need forecasts.)

The previous four steps of the methodology involved data identified by the planning area where care was provided. In order to determine the need for services for residents of a given planning area, patient days must be identified, instead, by the area where the patients live. Step 5, included as Appendix 5, identifies referral patterns in and out of the East Pierce planning area and illustrates where residents of the planning area currently receive care. For this calculation, the department separated patient days by age group (0-64 and 65 and older), and subtracted patient days for residents of other states. The department also uses hospital discharge data obtained from the Oregon Department of Human Services to identify patient days for Washington residents obtaining health care in Oregon (the department is not aware of similar data for the state of Idaho). As of the writing of this evaluation, the Oregon data for 2004 is unavailable. Therefore, the department has estimated the values for the numbers of Washington residents seeking care in Oregon hospitals by taking an average of those values in the most recent of several applications of the methodology.

As has been noted earlier, the original purpose for this methodology was to create comprehensive, statewide resource need forecasts. For this project, the state was broken into two planning areas – East Pierce and the state as a whole minus East Pierce. Appendix 5 illustrates the age-specific patient days for residents of the East Pierce planning area and for the rest of the state, identified here as "WA – East Pierce."

GSH also followed this step as described above with no deviations.

Step 6: Compute each hospital planning area's use rate (excluding psychiatric services) for each of the age groups considered (at a minimum, ages 0-64 and 65+).

Appendix 6 illustrates the age-specific use rates for the year 2004, as defined in Step 3, for the East Pierce planning area and for the rest of the state. No changes in this step were applied by GSH.

Step 7A: Forecast each hospital planning area's use rates for the target year by "trend-adjusting" each age-specific use rate. The use rates are adjusted upward or downward in proportion to the slope of either the statewide ten-year use rate trend or the appropriate health planning region's ten-year use rate trend, whichever trend would result in the smaller adjustment.

As discussed in Step 4, the department concluded that the nine-year use rate trends for 1996-2004 reflect the behavior of Washington residents more accurately than the ten-year use rate trends for 1995-2004. The 2003 use rates determined in Step 6 were multiplied by the slopes of both the planning area's eight-year use rate trend line and by the slope of the statewide eight-year use rate trend line for comparison purposes. For the East Pierce planning area, the area trend is a lower rate of increase (an annual increase of 1.1164) than the statewide rate (an annual increase of 3.0705). As directed in Step 7A, the department applied the planning area trend to project future use rates.

GSH applied this portion of step 7 with no modifications, except that the different calculation of use rate resulting from GSH's definition of East Pierce returned an annual rate of DECREASE in the planning area use rate of .91.

The methodology is designed to project need in a specified "target year." GSH's project expects 30 beds would be added by September 2011, and year 2012 would be GSH's first full year of operation as a 255 bed hospital. It is the practice of the department to evaluate need for a given project through at least three years following completion of the project. As a two-phase project, three years following completion of the entire project would be year 2015.

For this project, 2010 was also selected as the target year for the illustrative calculations in Appendices 7 through 9. In addition, the department used the methodology to project need for the East Pierce planning area over a series of years--from 2004 to 2015. The department's projections are presented in the summary attached as Appendix 10 of this analysis.

As previously stated, in its calculations, GSH applied the planning area trend. GSH also prepared projections through 2015.

Step 8: Forecast non-psychiatric patient days for each hospital planning area by multiplying the area's trend-adjusted use rates for the age groups by the area's forecasted population (in thousands) in each age group at the target year. Add patient days in each age group to determine total forecasted patient days.

Using the statewide forecasted use rate for the sample target year 2010 and medium series population projections prepared by OFM for the state and the planning area, the department's projected patient days for East Pierce planning area residents are illustrated in Appendix 8. As noted in Step 7 above, forecasts have been prepared for a series of years and are presented in summary in Appendix 10 as "Total East Pierce Res Days."

GSH used this same approach in its projections.

Step 9 Allocate the forecasted non-psychiatric patient days to the planning areas where services are expected to be provided in accordance with (a) the hospital market shares and (b) the percent of out-of-state use of Washington hospitals, both derived from the latest statewide patient origin study.

Using the patient origin study developed for Step 5, Appendix 9 illustrates how the projected patient days for the East Pierce planning area and the remainder of the state were allocated from county of resident to the area where the care is projected to be delivered in the target year 2010. The results of these calculations are presented in Appendix 10 as "Total Days in East Pierce Hospitals."

GSH prepared this step as above, except that it trend-adjusted GSH's market share of East Pierce planning area days. The department rejects this trend-adjustment as inconsistent with both the SHP and adopted practice in preparation of acute care bed need projections. The department concludes that insufficient foundation has been laid in the application materials to justify this adjustment.

Step 10: Applying weighted average occupancy standards, determine each planning area's non-psychiatric bed need. Calculate the weighted average occupancy standard as described in Hospital Forecasting Standard 11.f. This should be based on the total number of beds in each hospital (Standard 11.b), including any short-stay psychiatric beds in general acute-care hospitals. Psychiatric hospitals with no other services should be excluded from the occupancy calculation.

The number of beds in the planning area was identified in accordance with the SHP standard 12.a., which states:

1. beds which are currently licensed and physically could be set up without significant capital expenditure requiring new state approval;
2. beds which do not physically exist but are authorized unless for some reason it seems certain those beds will never be built;
3. beds which are currently in the license but physically could not be set up (e.g., beds which have been converted to other uses with no realistic chance they could be converted back to beds);
4. beds which will be eliminated.

SHP determines the number of available beds in each HSA, by including only those beds that meet the definition of #1 and #2 above, plus any CN approved beds. This information was gathered through CN and Facilities and Services Licensing records. There is currently only one acute care hospital in the East Pierce planning area—the applicant. [source: CN and OHCS files]

The weighted occupancy standard for a planning area is defined by the SHP as the sum, across all hospitals in the planning area, of each hospital's occupancy rate times that hospital's percentage of total beds in the area. In previous evaluations, the department determined that the occupancy standards reflected in the 1987 SHP are higher than can be maintained by hospitals under the current models for provision of care. As a result, the department has adjusted the occupancy standards presented in the SHP downward by 5% for all but the smallest hospitals (1 through 49 beds). As a result of this change, the East Pierce

planning area's weighted occupancy has been determined to be 70%. This is reflected in the line "Wtd Occ Std" in Appendix 10.

While the methodology states that short-stay psychiatric beds should be included in the above total, the fact that all psychiatric patient days were excluded from the patient days analyzed elsewhere in the methodology makes their inclusion inconsistent with the patient days used to determine need.

GSH also reduced the weighted occupancy consistent with the reductions outlined by the department, and did not include short stay psychiatric beds within in its calculations.

Step 11: To obtain a bed need forecast for all hospital services, including psychiatric, add the non-psychiatric bed need from step 10 above to the psychiatric inpatient bed need from step 11 of the short-stay psychiatric hospital bed need forecasting method.

The applicant is not proposing to add psychiatric services at the facility. In step 10, the department excluded the short stay psychiatric beds from the bed count total. For these reasons, the department concluded that psychiatric services should not be forecast while evaluating this project.

GSH also did not provide psychiatric forecasts within its methodology.

Step 12: Determine and carry out any necessary adjustments in population, use rates, market shares, out-of-area use and occupancy rates, following the guidelines in section IV of this Guide.

Within the department's application of the methodology, adjustments have been made where applicable and described above. As mentioned above, GSH also made adjustments to market share.

Appendix 10a calculates the planning area bed need under the assumption that the existing 225 beds are maintained through year 2015 (i.e. this project is not approved). Appendix 10b demonstrates the impact of adding GSH's proposed 30 beds, resulting in 255 beds in year 2012. A summary of those appendices is shown below.

Table I
Appendix 10A and 10B Summary

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Planning Area # of beds	225	225	225	225	225	225	225	225	225	225
Appendix 10A	-19	-11	-2	7	13	20	27	34	41	49
Planning Area # of beds	225	225	225	225	225	255	255	255	255	255
Appendix 10B	-19	-11	-2	7	13	20	-3	4	11	19

A negative number indicates a surplus of beds. Numbers are rounded to whole numbers

As shown in Table I above, for year current year 2006, Appendices 10a and 10b illustrate a planning area surplus of 19 beds. Appendix 10a indicates the planning area is projected to

experience a shortage of 9 beds beginning in year 2009, or within three years from the writing of this evaluation. Without additional beds in the planning area, this shortage is projected to increase to 13 beds in year 2010 and 34 beds in 2013.

On the other hand, Appendix 10b illustrates the effect on the planning area of this project. Adding 30 beds for full year 2012 at GSH creates a surplus of 3 beds in the planning area. The surplus disappears the next year, showing a need for 4 additional beds in 2013, increasing to a need for 19 additional beds in 2015.

In summary, if this project is not implemented, the planning area is projected to experience a shortage of 7 beds beginning in year 2009, which increases to a shortage of 49 beds by the end of year 2015. If this project is implemented, the planning area will experience a surplus of 3 beds in year 2012. Within a year, that surplus has disappeared and a need for an additional 4 beds is indicated in 2013, increasing to a need for 19 beds by the end of 2015.

As demonstrated by the methodology above, the East Pierce planning area is projected to need additional bed capacity within three years. It is also clear that this project, as proposed, would not over-bed the planning area for more than one year.

In addition to the numeric methodology above, the department must also determine whether existing providers are available and accessible in the planning area. The applicant is the only provider of acute care in the East Pierce planning area. During the course of this review, the department received approximately 15 letters of support. Entities in support include the two other providers of acute care in Pierce County—Franciscan Health System, operator of St. Joseph Medical Center and St. Claire Hospital, and MultiCare Health System, operator of Tacoma General/Allenmore and Mary Bridge hospitals.

Based on just the numeric need methodologies prepared by both the applicant and the department, GSH's proposal to add 30 acute care beds is reasonable. GSH, however, also provided projected numbers of patient days in the revised financial projections as a part of its May 22, 2006 PUI response. In that document, GSH projected 61,981 patient days in fiscal year 2009, increasing to 73,126 in fiscal year 2014. These patient days equate to 66.3% occupancy in 2009, increasing to 78.4% in 2014.

The department notes that GSH's patient day estimates are 5% to 8% higher than those returned by the department's need methodology. GSH's patient day estimates are also 7.6% to 11.7% higher than projected patient days from its own version of the need methodology. GSH has provided no explanation for this difference. Because of this significant difference between projected patient days and the number of patient days relied upon by the applicant in crafting its financial projections, the department is unable to conclude that those financial projections are based on reasonable assumptions. While this does not weaken GSH's ability to demonstrate that an additional 30 acute care beds are projected to be needed in the East Pierce planning area, it does affect the department's determination that the project proposed by GSH is financially feasible. That issue is discussed later in this evaluation.

Based on the above evaluation, the proposal by GSH to add 30 acute care hospital beds is consistent with this sub-criterion of need.

(2) All residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the proposed health service or services.

To demonstrate compliance with this sub-criterion, GSH provided copies of the following policies and procedures: Acute Care Patient Admit Process; Assessment, Admission and Daily Patient Care; Patient Admission Assessment Procedure and Documentation and Charity Care. [source: Application, Exhibits 6 and 7] None of these individual policies confirm that all residents of the service area, including low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly are likely to have adequate access to the hospital or charitable care at the hospital.

When questioned on this issue, GSH replied that "Patients are admitted to GSH based solely on medical need. Consistent with Washington State law, GSH's charity care and patient care services policies (i.e., EMTALA), not its admission policy ensure that individuals, regardless of residency, age income, race, ethnicity, gender or handicap will be provided with medically necessary care." [source: Applicant's November 29, 2004, responses to screening questions, p6] In its response, GSH cites EMTALA (the Emergency Medical Treatment and Labor Act, U.S.C. § 1395dd) and WAC 246-453-070 as the regulatory policies with which they comply, thus demonstrating compliance with this criterion. The department notes that EMTALA is specific to provision of emergency services and treatment of women in active labor. It does not address hospitalization for non-emergent conditions. WAC 246-453-070 is similarly limited for the purposes of this discussion, because it is specific to the needs of indigent persons.

The department did, however, locate information on GSH's web site that addresses the accessibility of the hospital to underserved groups. A document titled "Good Samaritan Community Healthcare Summary Standards of Conduct" states, "GSCH will not discriminate against employees or patients on the basis of race, religion, gender, sexual orientation, ethnic orientation or religious affiliations. [source: GSH website at http://www.goodsamhealth.org/pdf/GSCH_Summary_Standards.pdf] The department concludes that these standards, in conjunction with the documents discussed above, does provide the department with reasonable assurance that services at the hospital are and will be available to the underserved groups identified in WAC 2469-310-210(2).

For charity care reporting purposes, OHPDS, divides Washington State into five regions: King County, Puget Sound (less King County), Southwest, Central, and Eastern. GSH is one of 18 hospitals located within the Puget Sound Region. According to 2002-2004[4] charity care data obtained from OHPDS, GSH has historically provided an average of charity care greater than the Puget Sound regional average. GSH's most recent three years (2002-2004) percentages of charity care for gross and adjusted revenues are 1.82% and 3.55%, respectively. The 2002-2004 average for the Puget Sound Region is 1.28% for gross revenue and 2.62% for adjusted revenue. [source: OHPDS 2002-2004 charity care summaries] GSH's

[4] Year 2005 charity care data is not available as of the writing of this evaluation.

pro formas and current charity care policies both indicate that the hospital will provide charity care, although the percentage of charity care to be provided is not identified in either document. [source: GSH November 29, 2004, screening responses, Attachment 9]

Based on the above information, the department concludes that the applicant has effectively demonstrated that all residents of the service area currently have adequate access to the health services at GSH. Further, the information demonstrates that the additional 30 beds would not negatively affect this access, and patients would continue to have access to the health services at GSH. This sub-criterion is met.

B. Financial Feasibility (WAC 246-310-220)

Based on the source information reviewed, the department determines that the applicant has not met the financial feasibility criteria in WAC 246-310-220.

(1) The immediate and long-range capital and operating costs of the project can be met.

To analyze short- and long-term financial feasibility of hospital projects and to assess the financial impact of a project on overall facility operations, the department uses financial ratio analysis. The analysis assesses the financial position of an applicant, both historically and prospectively. The financial ratios utilized are **1)** long-term debt to equity ratio; **2)** current assets to current liabilities ratio; **3)** assets financed by liabilities ratio; **4)** total operating expense to total operating revenue ratio; and **5)** debt service coverage ratio. If a project's ratios are within the expected value range, the project can be expected to be financially feasible.

Table III below shows the financial ratios that GSH projects for years 2004 and 2009 through 2014 for the hospital as a whole, with the requested 30 additional beds and the Office of Hospital and Patient Data Systems (OHPDS) year 2004 financial ratio guidelines for hospital operations. [source: OHPDS analysis, pp4 & 5]

Table III
Good Samaritan Hospital's Projected Financial Ratios

Financial Ratio	OHPDS Guideline		Year 2004	Year 3 2011	Year 4 2012	Year 5 2013	Year 6 2014
Long Term Debt to Equity	0.530	* Below	0.475	0.386	0.342	0.310	0.282
Current Assets/Current Liabilities	2.067	* Above	1.674	1.401	1.406	1.421	1.431
Assets Financed by Liabilities	0.429	* Below	0.395	0.336	0.312	0.292	0.274
Total Operating Expense to Total Operating Revenue	0.969	* Below	0.987	0.935	0.919	0.906	0.898
Debt Service Coverage	4.307	* Above	18.027	5.167	5.427	5.876	6.154

* = a project is considered more feasible if the ratios are above or below the value/guideline as indicated

As noted in Table III, GSH projects a better than average financial position in three of five ratios as a 225 bed facility, and four of five ratios as a 255 bed facility. After reviewing the financial information provided by GSH, staff from OHPDS stated the following:

> "2014 fiscal year end ratios (CON year 6) for Good Samaritan Hospital are better than the State average or are within appropriate range of the state 2004 figures except for Current and Operating Income which are unreasonably optimistic. Current is low because the Hospital projects putting excess funds in Board Designated Assets rather than cash but the extra cash is available only due to unrealistic profit or operating margins more than double the state average. Statewide Operating Expense to Revenue in 2004 is 3.01% while Good Samaritan is projecting 10.2% in 2014. Historically, 1997 was the last year Good Samaritan reported operating margin anywhere near 10%." [source: OHPDS analysis, p3]

OHPDS staff also evaluated recent financial performance of GSH and provided the following commentary:

> "Recently the hospital has been operating at a significant loss… The recent reports show a total operating loss for the last 4 quarters of $12,765,452. However the hospital did report a profit for the previous four quarters (2005 Q1 through 2004 Q2) of $5,034,475.
>
> "The assets of Good Samaritan can withstand the 4 quarters of loss in the short term, however the hospital will need to turn this situation around quickly or they may not be able to meet legal obligations that long-term debt normally carries. According to the 2005 audited report of Good Samaritan Hospital, the long-term debt is from Washington Health Care Facilities Authority Revenue Bonds Series 2001. According to the audit notes, the bonds require certain financial ratios to be within fixed ranges. Some of these include minimum days' cash on hand, debt service coverage ratios, and other liens against assets. The bond is attached not just to the hospital but to all the entities covered by Good Samaritan Community Healthcare. While CN has no information on the exact ratio requirements, continual operating losses will severely hamper meeting those requirements. CN however does not have any information on what the penalty is for not meeting those ratio obligations. Also, if the hospital is operating at a loss, then board designated reserves and "cash from operations" availability are severely hampered." [source: OHPDS analysis, pp3-4]

As requested by the department, GSH provided two sets of financial projections to demonstrate compliance with this sub-criterion. The first set shows projected revenues and expenses for years 2009 through 2014 and includes the proposed 30 bed addition in late 2011. Year 2012 is projected to be the facility's first full year of operation as a 255 bed hospital. The first set shows projected revenues and expenses for the same timeframe as a 225 bed hospital, with no bed additions. Both sets demonstrate financial solvency for the hospital. Below is a summary of the first set of projections. [source: May 19, 2006, PUI responses, Attachment 4]

As a 225-bed hospital, GSH projects 69,101 patient days in year 2012[5], which is the first full year of operation following the addition of the 30 beds. In subsequent years through 2014, patient days are projected to increase an average of 6% per year. Tables IV below details the projected revenues and expenses for GSH for 2009 through projected year 2014. [source: May 19, 2006, PUI responses, Attachment 4]

Tables IV
Good Samaritan Hospital
Projected Revenue and Expenses Years 2009 through 2014

	2009	2010	2011
Number of Beds	225	225	225-255
Number of Admissions	15,470	16,365	17,067
Number of Inpatient Days	61,981	65,076	67,630
Net Operating Revenue*	$197,622,000	$ 205,561,000	$ 212,224,000
Total Operating Expense	$ 192,218,588	$ 196,175,869	$ 198,391,509
Operating Profit	$5,403,412	$9,385,131	$13,832,491
Operating Revenue per Inpatient Day	$3,188	$3,159	$3,138
Total Operating Expense per Inpatient Day	$3,101	$3,015	$2,933
Net Profit per Inpatient Day	$180	$233	$290

	2012	2013	2014
Number of Beds	255	255	255
Number of Admissions	17,418	18,120	18,471
Number of Inpatient Days	69,101	71,665	73,126
Net Operating Revenue*	$215,950,000	$222,613,000	$226,339,000
Total Operating Expense	$198,515,785	$201,747,425	$203,351,700
Operating Profit	$17,434,215	$20,865,575	$22,987,300
Operating Revenue per Inpatient Day	$3,125	$3,107	$3,095
Total Operating Expense per Inpatient Day	$2,873	$2,816	$2,781
Net Profit per Inpatient Day	$336	$372	$393

Note: whole numbers may not add due to rounding
*Includes deductions for bad debt, contractual allowances, and charity care

As shown in Tables IV above, GSH anticipates a profit in year 2009 with its existing 225 beds. With additional beds, the projected net profits increase substantially, for years 2012 through 2014. OHPDS staff reviewed the projections above and the detailed pro forma cost center data provided by the applicant and determined the projections not to be reasonable. OHPDS provided the following discussion of GSH's projected financial statements:

> "I reviewed the pro-forma balance sheet with project and income statement with project. The pro-forma income statement shows very large expectations, up to a 10.2% operating

[5] All patient day projections exclude DRG 391-normal newborn.

profit, which fuels the tripling of board designated assets in just six years. This expectation is unreasonable. A 3.1% operating profit, which is the statewide average for 2004, is much more realistic. Redoing the applicant's pro-forma with the statewide average operating profit of 3.1% does show the project is still financially feasible if the hospital admissions and patient day projections are met.

"All the pro-forma results are based on a certain volume of care. The patient day projections are 19% to 41% higher than current levels (2005-2002) of patient days which have been hovering around 52,000 patient days according to the Comprehensive hospital abstract reporting system (Chars) which is run the by the Washington State Department of Health. The data is for all patients reported from Good Samaritan and does not exclude normal newborn or psychiatric diagnosis related groups.

"The projection of 19% to 41% higher patient day volumes during the first six years of the project than current experience seems to be unreasonable. Again, the volumes recited in the application need to be met or the projected operating income, expenses and profit will be quite different. Both long term fixed costs such as debt payments and short term fixed costs such as certain contracted services must be paid no matter the volume of activity. Because of the overly optimistic income statement and patient volumes, the long term operating cost of the project may not be able to be met."

"Review shows that because the CN capital expenditure for this project is part of a much larger project and that the entire project budget would adversely impact reserves, total assets, total liability and equity of Good Samaritan Hospital, the immediate capital expenditure cannot be met." [source: OHPDS analysis, pp4-5]

Within the need portion of this evaluation, the department concluded that the addition of 30 beds has been demonstrated. The department further concluded that GSH's projected patient days appeared unreasonably high, given the projected need in the planning area and the historical volumes experienced by the hospital. Because the department concludes that the utilization rates upon which the projected financial statements were based are unreliably high, the department concludes that GSH has not demonstrated that it would be able to meet its short and long term financial obligations, and the capital and operating costs of the project would not be met. This sub-criterion is not met.

(2) <u>The costs of the project, including any construction costs, will probably not result in an unreasonable impact on the costs and charges for health services.</u>

OHPDS compared GSH's costs and charges to the statewide averages and determined that they are reasonable. OHPDS continued, however, with the statement, "However, these results are not useable because the volume projections are not realistic. This criterion is not satisfied." [source: OHPDS analysis, p6]

As previously stated, GSH is currently constructing a new, 168,000sf patient tower, of which one floor would be used to house the 30 beds to be added in phase two of the project. GSH did not indicate whether the tower would be constructed if this project is denied. The capital expenditure for the entire patient tower project was initially estimated at $92,368,000. Of

that amount, 8.8% or $8,134,878 was associated with the bed addition portion of this project. In its response to the department's PUI, GSH provided a revised capital expenditure for the 30 bed addition of $12,228,385. GSH did not provide a revised capital cost for the overall tower addition. The department notes that this revised cost is an increase of 50.32% over the original amount. Table V, below, illustrates the original and revised capital costs for this project:

Table V
Good Samaritan Hospital
Original and Revised Capital Cost Estimates

Item	Original Cost	Revised Cost	Percentage Increase
Land Purchase	0	0	0
Utilities to Lot Line	0	0	0
Land Improvements	0	0	0
Building Purchase	0	0	0
Residual Value of Facility	0	0	0
Building Construction	$6,462,116	$7,739,000	19.76%
Fixed Equipment	0	$580,425	New Item
Moveable Equipment	$468,503	$1,564,871	234%
Architect/Engineer Fees	$1,136,525	$928,680	-18.29%
Consulting Fees	0	$309,560	New Item
Site Preparation	0	$440,000	New Item
Supervision and Inspection	0	$464,340	New Item
Costs Associated with Financing	0	0	0
Sales Tax			
Building Construction	0	0	0
Moveable Equipment	$41,228	$137,709	234%
Other Project Costs:			
Review Fees	$26,506	$63,800	140.70%
TOTAL	**$8,134,878**	**$12,228,385**	**50.32%**

The department considers a change in the capital cost of a project to constitute amendment of this application under the terms of WAC 246-310-100(1)(d). WAC 246-310-100(5) specifies that amendment of an application may occur "…during the screening period or the public comment period." Because both the screening and public comment periods have ended, this application may no longer be amended. Because no amendment may now be submitted, the application must be denied. This sub-criterion is not met.

(3) The project can be appropriately financed.
OHPDS staff provided the following discussion of this sub-criterion:

> "Good Samaritan Hospital will use reserves for all costs of the CN project. The overall project will use reserves, "cash from operations" and long-term debt. The hospital is committing a large amount of the hospitals assets on the overall project. According to the various documents the hospital provided which include the 2004 and 2005 audited balance

sheet, Good Samaritan has the reserves to fund the CN portion of the project however it is not reasonable to assert that Good Samaritan can fund the $42,368,000 it projects it will use of reserves for the overall project. Information about the assets of the parent corporation, Good Samaritan Community Healthcare (GSCH) financial information was not available. The audited financial documentation for Good Samaritan Hospital notes that at the end of 2005, $20,448,000 was in "pooled investments at GSCH." CN has no information on any restrictions on these funds. The hospital does have $36,806,000 in Board Designated assets that should cover the CN capital expenditures. For the overall project, the long-term debt application status is unknown.

"The use of cash is a very appropriate and inexpensive financing method since the only constraint would be the question, is this the best use of the cash.

"While the financing methods used are appropriate business practice, the hospital has not demonstrated that this financing method is appropriate given their current financial status. This criterion is not satisfied." [source: OHPDS evaluation, pp6-7]

C. Structure and Process (Quality) of Care (WAC 246-310-230)

Based on the source information reviewed, the department determines that the applicant has met the structure and process (quality) of care criteria in WAC 246-310-230.

(1) A sufficient supply of qualified staff for the project, including both health personnel and management personnel, are available or can be recruited.

GSH provided estimates that the addition of 30 acute care beds to the hospital will require an increase of approximately 88 FTEs, including employed and contract staff, between 2004 (the last year for which actual FTEs were provided by the applicant) and the first year of phase two with 255 acute care beds (year 2012). By the third year of phase two, as a 255 bed facility--year 2012--GSH anticipates another 33 FTEs would be added. This increase also includes staff under contract with the hospital. In short, with implementation of both phases of the project, almost 121 FTEs are anticipated to be added at GSH. [source: Application, p82, November 29, 2004, supplemental information, p11, May 19, 2006, PUI responses, Attachment 4]

In the time between the submission of GSH's application and the writing of this evaluation, GSH announced the reduction of approximately 140 positions. [source: Tacoma News Tribune, April 29, 2006] This reduction was explained in GSH's PUI responses as an effort to correct "staffing inefficiencies." [source: May 19, 2006, PUI responses, pp3-4] GSH's revised pro-forma financial statements provided in the PUI responses reflect a reduction from anticipated 2006 FTE's per adjusted occupied bed of 5.4 to 5.02 FTEs per adjusted occupied bed by the third year of the project. GSH provided assertions in both the initial application and in the PUI responses that GSH "continually reviews its salary and benefit levels to ensure that it is competitive with other hospitals in the region." In its PUI response, GSH adds the contention that "GSH believes that the recent changes it has undertaken to add and/or expand programs and services coupled with its ongoing efforts to review and update salaries and benefits serve to make it a desirable employer in the East Pierce County Hospital Planning Area." GSH also notes that it is the only hospital in the planning area, providing it with an opportunity to attract the services of healthcare workers who live in the area and would prefer to work in the area as well.

Based on the information provided in the application, the department concludes that GSH provided, within its application, a reasonable assurance that it can recruit staff necessary for the proposed project. This sub-criterion is met.

(2) The proposed service(s) will have an appropriate relationship, including organizational relationship, to ancillary and support services, and ancillary and support services will be sufficient to support any health services included in the proposed project.
GSH states that "As GSH currently operates all of the ancillary and support departments needed to support an acute care institution, GSH has determined that existing Hospital support departments will be more than adequate to meet the additional demands resulting from the bed addition." [source: Application, p83] The department concludes that, since this application proposes an increase in bed capacity of only approximately 13%, and that no new specialty services or significant changes in healthcare delivery are expected to result from this bed addition, GSH's assertions that current support services are sufficient to support the project are reasonable.

Therefore, the department concludes that there is reasonable assurance that GSH will continue its relationships with ancillary and support services within the hospital, and approval of this project would not affect those relationships. This sub-criterion is met.

(3) There is reasonable assurance that the project will be in conformance with applicable state licensing requirements and, if the applicant is or plans to be certified under the Medicaid or Medicare program, with the applicable conditions of participation related to those programs.
In the spring of 2005, GSH requested suspension of review of this project. This request was precipitated by a survey of the facility by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). During the survey, GSH provided JCAHO with information that a staff member had supplied JCAHO with inaccurate information and forged signatures. As GSH notes in its PUI responses, this inaccurate and forged information automatically resulted in a preliminary recommendation that accreditation be denied. In April, 2006, GSH provided the department with the results of JCAHO's follow-up survey. That final survey recommended full accreditation. The department notes that this level of accreditation is superior to the level of accreditation received in the 1996, 1999 and 2002 surveys, which recommended accreditation with requirements for improvement. The department, on examination of the current survey document, concludes that the cause of the initial recommendation that accreditation be denied has been corrected.

In addition to the surveys performed by JCAHO, the department's Office of Health Care Survey conducted a re-licensure survey of GSH in December, 2004. In that survey, department staff also investigated several complaints against the facility. While no deficiencies were identified as a result of the complaints investigated, the department did identify several deficiencies through its routine survey. GSH prepared a plan of correction that was approved by the department.

In addition to acute care services, GSH also provides Medicare certified home health and hospice services in Pierce and King counties. GSH also operates an ambulatory surgery

center. [source: CN historical files] Since 2002, the Department of Health's Office of Health Care Survey (OHCS) has completed two compliance surveys for Good Samaritan In-Home Service[6] and one survey of Good Samaritan Surgery Center. Each of the compliance surveys revealed minor deficiencies typical for the type of facility and GSH submitted a plan of corrections and implemented the required corrections. [source: compliance survey data provided by Office of Health Care Survey]

Based on GSH's hospital and home health agency compliance history, the department concludes that there is reasonable assurance that the hospital would continue to operate in conformance with state and federal regulations with the additional acute care beds.

(4) The proposed project will promote continuity in the provision of health care, not result in an unwarranted fragmentation of services, and have an appropriate relationship to the service area's existing health care system.

In its initial application, GSH noted that additional acute care capacity would enable it to serve the community better by accommodating an expected increase in patient days. GSH also noted that additional capacity would enable it to accommodate emergent patients delivered to the hospital via the EMS system more-readily. [source: Application, pp37 and 84] In its PUI response, GSH added a discussion of "diseconomies and inefficiencies associated with operating at and above optimal occupancy levels." The department concludes that the first two factors – increased patient days and response to EMS system demands would likely be satisfied by addition of the requested beds at GSH. The department notes, however, that the third factor – stresses to a facility's ability to function efficiently due to excessive utilization would not be relieved if future patient days are as high as GSH projected in its PUI responses. As noted earlier in the need section of this evaluation, GSH projects to be operating in excess of 78% occupancy by the third year following project completion. Given that GSH has not operated above 61% occupancy of its licensed beds in the most recent seven years for which occupancy rates are available, the department must conclude that any stresses to the hospital that exist at 60% occupancy would likely still exist, if not in greater magnitude, at 78% utilization. The department cannot conclude that, if GSH's projected utilization were to be realized, that this project would remedy any "diseconomies and inefficiencies" caused by operating above optimal occupancy levels.

The department concludes that there is reasonable assurance that addition of the thirty beds requested in this project would assist in GSH's ability to continue to promote continuity of care through increased ability to admit emergent and non-emergent patients. Further, GSH's relationships within existing health care system would continue and not result in an unwarranted fragmentation of services. This sub-criterion is met.

(5) There is reasonable assurance that the services to be provided through the proposed project will be provided in a manner that ensures safe and adequate care to the public to be served and in accord with applicable federal and state laws, rules, and regulations.

This sub-criterion is addressed in sub-section (3) above and is considered met.

[6] Surveys completed in 2002, 2003 and 2005.

D. Cost Containment (WAC 246-310-240)

Based on the source information reviewed, the department determines that the applicant has not met the cost containment criteria in WAC 246-310-240.

(1) Superior alternatives, in terms of cost, efficiency, or effectiveness, are not available or practicable.

In response to this sub-criterion, GSH examined three alternatives to this project: 1. Do nothing; 2. Expand outpatient capacity only; and 3. Create a satellite inpatient facility away from the existing GSH campus. [source: Application, p87] Because of the need calculations prepared by the applicant, GSH concluded that the first option was not an appropriate choice. GSH also eliminated the second alternative because addition of outpatient capacity would do little or nothing to alleviate the projected need for inpatient capacity. Finally, the third option was discarded because it would necessarily create higher costs than the current proposal due to duplication of the hospital services necessary to support acute care.

Given the need identified by both the applicant and the department, the department concludes that the GSH proposal to add 30 acute care beds would be a suitable solution to the near-term acute care needs of the East Pierce Planning area. The department notes, however, that its review of GSH's projected utilization and the financial projections developed to support this project has created doubt about the financial feasibility of GSH's planned expansion. The department also notes that the applicant stated on page 10 of the application that the facility currently operates only 195 of its 225 licensed beds. Since 1998, the highest number of available beds reported by GSH is 211. Since 2001, that number has been between 173 and 197 available beds. As identified in the chart on page 18 of the application, this proposal would have the practical effect of adding 60 beds to the East Pierce planning area. The department concludes that much of the need for additional access to acute care beds for planned and emergent admissions alike would be alleviated by GSH operating its full licensed capacity of 225 beds, 30 more than currently in use. These factors combine to make the department unable to conclude that GSH's request for 30 additional beds, under the utilization projected in the PUI responses, is the best alternative to meet the East Pierce planning area's projected need for additional acute care beds; therefore, this sub-criterion is not met.

(2)(a) In the case of a project involving construction: The costs, scope, and methods of construction and energy conservation are reasonable.

Staff from OHPDS examined the construction costs of this project and provided the following analysis:

> **"**The costs shown are within past construction costs reviewed by this office. Also construction cost can vary quite a bit due to type of construction, quality of material, custom vs. standard design, building site and other factors. Good Samaritan Hospital is building in a facility it currently occupies for healthcare services and will construct the new area to the latest energy and hospital standards.
>
> Staff is satisfied the applicant plans are appropriate. This criterion is satisfied." [source: OHPDS evaluation, p7]

(2)(b) In the case of a project involving construction: The project will not have an unreasonable impact of the costs and charges to the public of providing services by other persons
This criterion is addressed above in 266-310-230(2) and is not met.

(3) The project will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment and which promote quality assurance and cost effectiveness.
OHPDS provided the following discussion of this criterion:

> "Good Samaritan Hospital notes that this project will improve system efficiency for the hospital and patients as the new beds will be in private rooms which give more flexibility and makes it much easier to place patients in the most appropriate clinical level. The hospital also notes several other system improvements that they will be able to do because of building new.
>
> Staff is satisfied the project is appropriate and needed. This criterion is satisfied." [source: OHPDS evaluation, p7]

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APPENDICES